

Maricopa County RETIREES

Enrollment / Change Form

Reason For Completing Form Please Mark One	Please Print									
New Retiree Retirement Date:/_/				irst Name		MI				
New Retiree Retirement Date:/_/										
Retirement Date:/ COBRA Coverage Expiration Date Ended:// Cancel Coverage as of/_/ O Medical & Dental O Dental Only Re-enrollment is not permitted after cancellation of coverage. Retiree Medical Plan Options HMO CMG High Option OAP In-network CIGNA Medicare Select Plus Rx (spouse only) CMG (if spouse is on CIGNA Medicare Select Plus Rx) Same plan as retiree (Spouse &/or family) Pharmacy Plan Options Must Choose One To Accompany Medical Plan Options Must Choose One To Accompany Medical Plan Options Decline Dental Plan Options Decline Dental Services CIGNA Dental Services Retiree & Spouse Retiree & Collad Plan to Elect Dental Employers Dental Services Retiree Demographic Information Employee ID# Requesting Alternate ID #? No Pyes (Must submit Alt. ID Request Form) Marital Status: Single Married Divorced Widowed Medicare Information: Do not have Medicare Plate Medicare Part A &/or B Medicare Information: Do not have Medicare Plate Medicare Part A &/or B Date of Birth Gender PSPRS Retiree ECORP Retiree EORP Retiree CORP Retiree CORP Retiree CORP Retiree CORP Retiree CORP Retiree PORP Retiree CORP Retiree EORP Retiree CORP Retiree CORP Retiree CORP Retiree CORP Retiree CORP Retiree PORP Retiree CORP Retiree PORP Retiree CORP Retiree COP Plan Option CIGNA Medicare Select Plus Rx (Must be enrolled in										
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Please attach a copy of your Medicare card □ Male □ Female	Please attach a copy of your Medicare card			ט ווי	Bato of Birth		□ Male □ Female			
Mailing Address City State Zip					State	Zip				
AZ						ΑZ				
Email Address Home Phone # Cell Phone #	Email Address Home Phone #					l.				
Contact Name Contact Phone # Contact Address	Contact Name Contact Phone #		#			Contact Address				

Return to: Maricopa County Employee Health Initiatives Department 301 W Jefferson, Suite 201 Phoenix, AZ 85003 Phone: 602-506-1010

Pnone: 602-506-1010 Fax: 602-506-2354

Dependent/Beneficiary Section										
Eligible dependents who can be covered under your plan include your:										
Legal spouse										
Child under age 19										
• Your unmarried child, of any age, who resides with you and is medically certified as disabled prior to his/her 19 th birthday or prior to age 25, if disabled while a full-time student.										
 Your unmarried child between the ag 										
dependent upon you for support or maintenance (you must provide more than 50% of his/her support). You must supply 3 rd party										
documentation from the school show										
Dependent/Beneficiary Informati	on									
Enroll Eligible Dependent for Medical Medical & Dental Plan	RELATIONSHIP			ld (under 19) ne Student (19 and older)	☐ Handicapped Child☐ Legal Guardianship					
Social Security # (Voluntary)	Last Name	First Name		Date of Birth	GENDER					
					☐ Male ☐ Female					
Mailing Address		City		State	Zip					
□ Same as retiree's Medicare Information □ Do n	ant bour Madiana	D. Haya Madiaara [Dow! A 0/or	. D. O						
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Dependent/Beneficiary Informati	on									
Enroll Eligible Dependent for Medical Dental Plan	RELATIONSHIP	3 1		ld (under 19) ne Student (19 and older)	☐ Handicapped Child☐ Legal Guardianship					
Social Security # (Voluntary)	Last Name	First Name		Date of Birth	GENDER					
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Mailing Address		City		State	Zip					
Same as retiree's Medicare Information Do n	ot have Medicare	□ Have Medicare P	Part A 9/or	D Diago attach a con-	of your Madiagra agree					
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Additional plan forms and provider inf										
Once your plans go into effect, you must have a "Qualified Status Change" as defined by the IRC Section 125 in order to modify your Medical or Poptal plan elections, information about qualified status changes can be found in the Know Your Benefits quide. It is your										
Medical or Dental plan elections. Information about qualified status changes can be found in the <i>Know Your Benefits</i> guide. It is your responsibility to submit the change request form to the Employee Health Initiatives department and attach appropriate 3 rd party										
documentation of the qualifying event within 30 calendar days of a status change.										
Authorization										
By submitting my open enrollment request or continuing with my current health care coverage, I understand and agree that Maricopa										
County may share protected health information (PHI) concerning me and my dependents, as described in the Maricopa County Notice of										
Privacy Practices, with my health care providers which could include CIGNA HealthCare of AZ and CIGNA Dental, Walgreens Health										
Initiatives (WHI), Magellan Health Services, Delta Dental, Employers Dental Services (EDS) and EyeMed Vision Care. I further agree to release Maricopa County and Maricopa County's health care providers from any liability for any good fait release of PHI in connection with										
		ders from any liability	for any go	ood fait release of P	HI in connection with					
my benefits or as otherwise authorized or required by law.										
I acknowledge and agree that I am responsible for and will pay the full amount of any premiums due regardless of receipt of subsidy from										
any qualifying Retirement System, such as ASRS or PSPRS. This means that if the applicable state retirement system fails to pay its										
premium subsidy, I am responsible for the entire premium amount due. I understand that failure to pay the full premium amount due for any										
reason may cause termination or interruption of my health insurance benefits and I further understand and agree that I will be liable and										
responsible for all claims incurred during such periods of non-coverage caused by non-payment of premiums.										
I certify to the best of my knowledge all information I have provided is accurate, correct and complete.										
Retiree Signature: Date:										
Retiree Signature:		U	ale							
For Office Use Only:	Monthly Drom!	¢		Coverage Code:						
Effective Date: Validation	Monthly Premium:	Ф	C	Coverage Code:						